DD-500-FF (6-07)
P/P/ Ch. 1000

ARIZONA DEPARTMENT OF ECONOMIC SECURITY
Division of Developmental Disabilities
INDIVIDUAL SUPPORT PLAN (ISP)

Clear The Form

SUPPORT COORDINATOR'S REVIEW OF THE ISP/IFSP/PCP

INDIVIDUAL'S NAME *(Last, First, M.I.)* | ASSISTS NO.

ELIGIBILITY

☐ ALTCS ☐ TSC ☐ DDD (state funded only) ☐ AzEIP

☐ Ventilator dependent program *(must send a copy to Health Services/Vent RN)*

FREQUENCY

☐ 90 Day ☐ 180 Day ☐ Other: _____

PERSONS PRESENT AT REVIEW *(Please include titles and agency name, if appropriate)*

LOCATION OF REVIEW | DATE OF REVIEW

OTHER TEAM MEMBERS CONSULTED

Name/Title	Agency	Date of Contact

Use the space below to write a narrative that describes *(if additional space is needed, use the DDD-1271A Continuation Page)*:

1. Your interactions with the person served. Note significant changes since the last ISP/IFSP and progress toward goals.
2. The individual's/responsible person's view of the individual's progress toward goals/objectives, satisfaction with services and providers and concerns about any unmet needs or gaps in service (providers not arriving for scheduled services). Document efforts to acquire needed services and supports.
3. The provider's and other team members' views of the individual progress and concerns about unmet needs Include information from provider's progress reports if provider not present).
4. Changes in the person's medical/functional status, such as change in the primary care provider (PCP), doctor's visits or hospitalizations, changes in physician's orders, new evaluations and/or follow-up to pervious evaluations/appointments, changes in medications, changes in durable medical equipment, or changes in behavioral health status.
5. If receiving behavioral health services, address how the individual is doing on their behavioral health objective(s)/outcome(s). Please gather information from the individual parent(s)/caregiver, and from conversations with the QBHP/clinical liaison.
6. Does the individual have private health insurance coverage? ☐ Yes ☐ No
   (Document any changes in coverage and enter into FOCUS.)

Clear The Form

7.	IF THERE ARE NEW PROFESSIONAL EVALUATIONS, HAS ALL REQUIRED FOLLOW-UP BEEN COMPLETED?	☐ Yes	☐ No	☐ N/A
8.	HAVE REPORTS FROM SERVICE PROVIDERS REGARDING ALL OBJECTIVES INCLUDING BEHAVIORAL HEALTH AND THERAPIES BEEN RECEIVED?	☐ Yes	☐ No	☐ N/A
9.	HAS PROGRESS BEEN MADE ON ALL GOALS AND OBJECTIVES?	☐ Yes	☐ No	☐ N/A
10.	DOES THE INDIVIDUAL RECEIVE THE SERVICES LISTED ON THE ISP REGULARLY?	☐ Yes	☐ No	☐ N/A
11.	HAS ATTENDANT CARE, HOUSEKEEPING, HABILITATION, INDEPENDENT (HAI) OR RESPITE BEEN RECEIVED AS SCHEDULED AND AGREED UPON WITH THE PROVIDER?	☐ Yes	☐ No	☐ N/A
12.	IF THE INDIVIDUAL RECEIVES ATTENDANT CARE OR HOUSEKEEPING, HAS THE APPROPRIATE MONITORING OCCURRED?	☐ Yes	☐ No	☐ N/A
13.	ARE ALL INDIRECT SERVICES INCLUDING EDUCATIONAL/VOCATIONAL SERVICES ENTERED IN FOCUS?	☐ Yes	☐ No	☐ N/A
14.	DO SERVICES ON THE ISP/CHANGE IN ISP MATCH THE FOCUS SERVICE PLAN?	☐ Yes	☐ No	☐ N/A
15.	ARE THESE SERVICES (Direct and indirect) SUFFICIENT AND APPROPRIATE TO MEET THE INDIVIDUAL'S NEEDS?	☐ Yes	☐ No	☐ N/A
16.	IF THE INDIVIDUAL IS WAITING FOR SERVICE(S), HAS HE/SHE BEEN OFFERED OR IS HE/SHE RECEIVING AN ALTERNATIVE SERVICE(S)?	☐ Yes	☐ No	☐ N/A
17.	IF THE INDIVIDUAL IS WAITING FOR SERVICE(S), HAS IT BEEN ENTERED INTO FOCUS?	☐ Yes	☐ No	☐ N/A
18.	IF THE INDIVIDUAL HAS NOT USED SERVICES IN THE LAST 90 DAYS, ARE ALTCS SERVICES STILL NEEDED? (Explain in narrative)	☐ Yes	☐ No	☐ N/A
19.	ARE SERVICE COSTS LESS THAN 80% OF INSTITUTIONAL CARE?	☐ Yes	☐ No	☐ N/A
20.	HAVE THE TEAM ASSIGNMENTS ON THE LAST ISP AND SUBSEQUENT REVIEWS BEEN COMPLETED?	☐ Yes	☐ No	☐ N/A
21.	IF NEEDED, HAS A REFERRAL BEEN MADE TO THE BEHAVIORAL HEALTH PROVIDER?	☐ Yes	☐ No	☐ N/A
22.	IS THE PBHP/QBHP ASSIGNMENT THE SAME?	☐ Yes	☐ No	☐ N/A
	Name: Title:			
23.	HAS THE CORRECT BEHAVIORAL HEALTH CODE BEEN ENTERED IN FOCUS?	☐ Yes	☐ No	☐ N/A
24.	IF THE PERSON RECEIVES PSYCHIATRIC/PSYCHOTROPIC MEDICATION, IS IT EFFECTIVE AND IS HE/SHE FREE FROM ADVERSE SIDE EFFECTS?	☐ Yes	☐ No	☐ N/A
25.	IS THE INDIVIDUAL/RESPONSIBLE PERSON SATISFIED WITH THE HEALTH PLAN/PCP (Primary Care Provider) AND MEDICAL FOLLOW-UP?	☐ Yes	☐ No	☐ N/A
26.	HAS THE ALTCS HEALTH PLAN PCP CODE (PRIMARY CARE PROVIDER) BEEN UPDATED IN FOCUS?	☐ Yes	☐ No	☐ N/A
27.	IS THE INDIVIDUAL/RESPONSIBLE PERSON ABLE TO LOCATE RESOURCES (e.g. housing, government benefits, etc.) WITHIN THE COMMUNITY?	☐ Yes	☐ No	☐ N/A
28.	HAS A RISK ASSESSMENT/PLAN BEEN COMPLETED/REVIEWED?	☐ Yes	☐ No	☐ N/A
29.	IF THE PERSON RECEIVES ATTENDANT CARE, HOUSEKEEPING, HABILITATION INDEPENDENT (HAI) OR RESPITE, HAS A BACKUP PLAN BEEN DEVELOPED TO ADDRESS PROVIDER NO SHOWS?	☐ Yes	☐ No	☐ N/A
30.	HAS THE BACK-UP PLAN BEEN SIGNED BY THE INDIVIDUAL/RESPONSIBLE PERSON AND INITIALED QUARTERLY?	☐ Yes	☐ No	☐ N/A

If you answered "No" to any of the questions above, explain and record necessary follow-up actions below. *(If additional space is needed, use the DDD-1271A Continuation Page)*

FOR TSC ONLY: DOES THE INDIVIDUAL/RESPONSIBLE PERSON WISH TO MAKE ANY CHANGES IN THE TYPE AND/OR FREQUENCY OF CONTACT

☐ Yes ☐ No Type _____ Frequency _____

- ♦ If appropriate, complete a PRE-PAS on TSC or DDD individuals and refer him/her to ALTCS.
- ♦ If changes are needed to the person's ISP as a result of this review, complete and attach DD-224, Changes in the ISP.
- ♦ Print the updated FOCUS Service Plan Screen and attach it to this review in the case file.

SUPPORT COORDINATOR'S SIGNATURE	SUPPORT COORDINATOR'S NAME *(Please print)*	DATE